		FOR OHF USE					

LL I

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 8000846

Facility Name: Fayette County Hospital

Address: Seventh & Taylor Streets (Number) Vandalia (City) 62471 (Zip Code)

County: Fayette

Telephone Number: 618/283-1232 **Fax #** 618/283-4608

IDPA ID Number: 37-6012895002

Date of Initial License for Current Owners: 1/1/71

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Kenneth J. Wieduwilt **Telephone Number:** 314/653-5317

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/99 to 6/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Dan Gantz

(Title) President

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number Fayette County Hospital # 8000846 Report Period Beginning: 7/1/99 Ending: 6/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	101	Skilled (SNF)	101	36,966	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	101	TOTALS	101	36,966	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,867	9,958	5,291	32,116	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,867	9,958	5,291	32,116	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.88%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1/1/71

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 18 and days of care provided 5291

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: N/A Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Fayette County Hospital # 8000846 Report Period Beginning: 7/1/99 Ending: 6/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	115,197	161,770	69,954	346,921	(123,188)	223,733	0	223,733			1
2	Food Purchase					122,915	122,915	0	122,915			2
3	Housekeeping	65,485	16,643	7,634	89,762	(1,575)	88,187	0	88,187			3
4	Laundry	57,338	21,860	5,244	84,442	(81)	84,361	0	84,361			4
5	Heat and Other Utilities					121,875	121,875	0	121,875			5
6	Maintenance	46,423	2,162	147,085	195,670	(125,647)	70,023	0	70,023			6
7	Other (specify):* Cafeteria							32,741	32,741			7
8	TOTAL General Services	284,443	202,435	229,917	716,795	(5,701)	711,094	32,741	743,835			8
	B. Health Care and Programs											
9	Medical Director							0				9
10	Nursing and Medical Records	1,300,839	76,970	224,119	1,601,928	(64,118)	1,537,810	37,554	1,575,364			10
10a	Therapy							293,686	293,686			10a
11	Activities							0				11
12	Social Services	34,277	384	4,669	39,330		39,330	0	39,330			12
13	Nurse Aide Training							0				13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16	TOTAL Health Care and Programs	1,335,116	77,354	228,788	1,641,258	(64,118)	1,577,140	331,240	1,908,380			16
	C. General Administration											
17	Administrative	93,168	980	136,512	230,660	(86,217)	144,443	0	144,443			17
18	Directors Fees							0				18
19	Professional Services					32,400	32,400	0	32,400			19
20	Dues, Fees, Subscriptions & Promotions							0				20
21	Clerical & General Office Expenses	20,297	184	288,848	309,329		309,329	0	309,329			21
22	Employee Benefits & Payroll Taxes							0				22
23	Inservice Training & Education							0				23
24	Travel and Seminar							0				24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice					53,817	53,817	0	53,817			26
27	Other (specify):*							0				27
28	TOTAL General Administration	113,465	1,164	425,360	539,989		539,989		539,989			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,733,024	280,953	884,065	2,898,042	(69,819)	2,828,223	363,981	3,192,204			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Fayette County Hospital # 8000846 Report Period Beginning: 7/1/99 Ending: 6/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation					70,976	70,976	0	70,976			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest							0				32
33	Real Estate Taxes							0				33
34	Rent-Facility & Grounds							0				34
35	Rent-Equipment & Vehicles							0				35
36	Other (specify):*											36
37	**TOTAL Ownership**					70,976	70,976		70,976			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers	3,479	114,123	25,829	143,431	(1,157)	142,274	80,299	222,573			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			56,268	56,268		56,268	0	56,268			42
43	Other (specify):*							0				43
44	**TOTAL Special Cost Centers**	3,479	114,123	82,097	199,699	(1,157)	198,542	80,299	278,841			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,736,503	395,076	966,162	3,097,741	0	3,097,741	444,280	3,542,021			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number Fayette County Hospital # 8000846 **Report Period Beginning:** 7/1/99 **Ending:** 6/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	444,280		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 444,280		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 444,280		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Preview

Detail lines 29 and 35 of Page 9 starting in B44. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.

The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 9A**

Facility Name **Fayette County Hospital**

IDH **0000818**

Report Period Beginning: **1/1/10**

Ending: **12/31/10**

To Print the Other Adjustments you have entered.

1. Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.

2. Push the Print Other Adjustments button.

Print Other Adjustments

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V Line	Adj. Summary
	The information listed in B13 thru G65 is from Page 5.				
1	**Day Care**	0	0	**Line 1**	0
2	**Other Care for Outpatients**	0	0	**Line 2**	0
3	**Governmental Sponsored Special Programs**	0	0	**Line 3**	0
4	**Non-Patient Meals**	0	0	**Line 4**	0
5	**Telephone, TV & Radio in Resident Rooms**	0	0	**Line 5**	0
6	**Rented Facility Space**	0	0	**Line 6**	0
7	**Sale of Supplies to Non-Patients**	0	0	**Line 7**	21,414
8	**Laundry for Non-Patients**	0	0	**Line 8**	21,784
9	**Non-Straight-line Depreciation**	0	0	**Line 9**	0
10	**Interest and Other Investment Income**	0	0	**Line 10**	27,104
11	**Discounts, Allowances, Rebates & Refunds**	0	0	**Line 11a**	297,889
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 11**	0
13	**Sales Tax**	0	0	**Line 12**	0
14	**Non-Care Related Interest**	0	0	**Line 12**	0
15	**Non-Care Related Owner's Transactions**	0	0	**Line 14**	0
16	**Personal Expenses (Including Transportation)**	0	0	**Line 15**	0
17	**Non-Care Related Fees**	0	0	**Line 16**	337,407
18	**Fines and Penalties**	0	0	**Line 17**	0
19	**Entertainment**	0	0	**Line 18**	0
20	**Contributions**	0	0	**Line 19**	0
21	**Owner or Key Man Insurance**	0	0	**Line 20**	0
22	**Special Legal Fees & Legal Retainers**	0	0	**Line 21**	0
23	**Malpractice Insurance for Individuals**	0	0	**Line 22**	0
24	**Bad Debt**	0	0	**Line 23**	0
25	**Public Relating, Advertising and Promotional**	0	0	**Line 24**	0
26	**Income & 11. Personal Property Replacement Taxes**	0	0	**Line 25**	0
27	**Nurse Aide Training for Non-Employees**	0	0	**Line 26**	0
28	**Yellow Page Advertising**	0	0	**Line 27**	0
29	**Non-Paid Workers**	0	0	**Line 28**	0
30	**Donated Goods**	0	0	**Line 29**	20,703
31	**Amortization Expense**	0	0	**Line 30**	0
32	Medical Records Expens	37,584	10	**Line 31**	0
33	Cafeteria	32,781	7	**Line 32**	0
34	Therapy Services	293,686	10a	**Line 33**	0
35	Ancillary Services	80,299	39	**Line 34**	0
36				**Line 35**	0
37				**Line 36**	0
38				**Line 37**	0
39				**Line 38**	0
40				**Line 39**	80,299
41				**Line 40**	0
42				**Line 41**	0
43				**Line 42**	0
44				**Line 43**	0
45				**Line 44**	50,795
46				**Line 45**	410,384

Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Fayette County Hospital # 8000846 Report Period Beginning: 7/1/99 Ending: 6/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	32,741	0	0	0	0	0	0	0	0	0	0	32,741	7
8	**TOTAL General Services**	32,741	0	0	0	0	0	0	0	0	0	0	32,741	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	37,554	0	0	0	0	0	0	0	0	0	0	37,554	10
10a	Therapy	293,686	0	0	0	0	0	0	0	0	0	0	293,686	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	331,240	0	0	0	0	0	0	0	0	0	0	331,240	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	363,981	0	0	0	0	0	0	0	0	0	0	363,981	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Number Fayette County Hospital # 8000846 Report Period Beginning: 7/1/99 Ending: 6/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense / D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	80,299	0	0	0	0	0	0	0	0	0	0	80,299	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	80,299	0	0	0	0	0	0	0	0	0	0	80,299	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	444,280	0	0	0	0	0	0	0	0	0	0	444,280	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT
FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Page 6

Facility Name & ID Number: Fayette County Hospital — # 0800846 — Report Period Beginning: 7/1/99 — Ending: 6/30/00

VII. RELATED PARTIES

Show Pgs 6A thru 6D | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Fayette County Hospital District	100			Alton Memorial Hospital	Alton, IL	Management Services

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item		4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization		8 Difference; Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Management Fees	$	32,400	Alton Memorial Hospital	100.00%	$ 32,400	$		1
2	V										2
3	V										3
4	V										4
5	V										5
6	V										6
7	V										7
8	V										8
9	V										9
10	V										10
11	V										11
12	V										12
13	V										13
14	Total			$	32,400			$ 32,400	$	-	14

Sum_6

* Total must agree with the amount recorded on line 30 of Schedule VI.

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DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

Facility Name & ID Number Fayette County Hospital # 8000846 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2		There were no payments to related parties.									2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Print Preview

Facility Name & ID Number Fayette County Hospital # 8000846 Report Period Beginning: 7/1/99 Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS [Show Pgs 8A thru 8D] [Show Pgs 8E thru 8I] [Hide Pgs 8A thru 8I]

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Fayette County Hospital
Street Address: Seventh & Taylor Streets
City / State / Zip Code: Vandalia, IL 62471
Phone Number: (618) 283-1232
Fax Number: (618) 283-4652

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Meals Served	136,157	5	$ 761,358	$ 133,560	95,982	$ 536,709	1
2	3	Housekeeping	Sq. Ft.	67,316	20	323,593	177,290	19,583	94,137	2
3	4	Laundry	Pounds	657,719	10	214,950	82,000	432,677	141,404	3
4	6	Maintenance	Sq. Ft.	69,361	22	922,250	145,989	19,583	260,383	4
5	7	Cafeteria	FTE's	174	15	211,770	15,041	65	79,256	5
6	10	Medical Records	Patient Revenues	25,022,050	18	256,549	122,986	3,254,774	33,371	6
7	17	A&G	Accumulated Costs	12,048,584	27	2,115,037	664,150	2,065,930	362,658	7
8	22	Employee Benefits	Gross Salaries	5,877,500	23	1,122,288	86,320	1,394,007	266,181	8
9	30	Old Capital - Bldg	Sq. Ft.	120,580	25	204,372	0	19,583	33,191	9
10	30	Old Capital - Equip	Dollar Value	14,369	16	19,032	0	1,068	1,415	10
11	30	New Capital - Bldg	Sq. Ft.	120,580	25	429,842	0	19,583	69,809	11
12	30	New Capital - Equip	Dollar Value	476,906	25	837,358	0	24,908	43,734	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 7,418,399	$ 1,427,336		$ 1,922,248	25

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Facility Name & ID Number Fayette County Hospital # 8000846 Report Period Beginning: 7/1/99 Ending: 6/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3	No interest expense is included in Schedule V. 100% of the interest expense is hospital related.											3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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Facility Name & ID Number Fayette County Hospital # 8000846 Report Period Beginning: 7/1/99 Ending: 6/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ ____ For 19 ____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995		8
1996		9
1997		10
1998		11
1999		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Preview

Facility Name & ID Number Fayette County Hospital # 8000846 Report Period Beginning: 7/1/99 Ending: 6/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,824 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

X., C&D, Fayette County Hospital District owns the facility and has an operating agreement with CH Allied Services, Inc.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Hospital & LTC	118,780	1968	$ 22,958	1
2					2
3	TOTALS	118,780		$ 22,958	3

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Facility Name & ID Number Fayette County Hospital # 8000846 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6				Hospital & LTC bldg are owned by the District and are on their records.							6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Cabinet and countertop			1991	678	34	20	34		320	9
10	Light fixtures			1991	12,323	1,251	10	1,251		11,698	10
11	Carpeting			1991	1,157	0	10			1,157	11
12	Boiler control			1991	1,211	123	10	123		1,079	12
13	Ceiling tile			1994	5,152	521	10	521		2,855	13
14	Florescent lighting			1994	5,826	588	10	588		3,228	14
15	Light fixtures			1994	1,937	196	10	196		1,090	15
16	Ceiling tile			1994	2,635	266	10	266		1,460	16
17	LTC Remodeling-painting			1994	7,068	604	5	604		7,068	17
18	Manifold system			1995	2,234	225	10	225		1,203	18
19	Nurse call system			1996	14,194	1,430	10	1,430		6,207	19
20	Sliding door			1996	10,189	1,027	10	1,027		4,027	20
21	Nurse call system			1996	67,423	6,794	10	6,794		29,488	21
22	Remodel 3rd floor			1997	419,073	27,927	15	27,927		79,287	22
23	Cabinetry dining room			1997	4,097		5				23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 40,986		$ 40,986	$	$ 150,167	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number Fayette County Hospital # 8000846 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 304,687	$ 27,299	$ 27,299	$		$ 145,596	37
38	Current Year Purchases	0	0	0			0	38
39	Fully Depreciated Assets	93,672	2,691	2,691			93,672	39
40								40
41	TOTALS	$ 398,359	$ 29,990	$ 29,990	$		$ 239,268	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 70,976	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 70,976	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 389,435	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

Facility Name & ID Number Fayette County Hospital # 8000846 Report Period Beginning: 7/1/99 Ending: 6/30/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

Facility Name & ID Number Fayette County Hospital # 8000846 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

Facility Name & ID Number Fayette County Hospital # 8000846 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				97,277		97,277	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Central Supply						15,596		15,596	13
14	TOTAL			$		$	$ 112,873		$ 112,873	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

Facility Name & ID Number Fayette County Hospital # 8000846 Report Period Beginning: 7/1/99 Ending: 6/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 308,771	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		3,869,561	3
4	Supply Inventory (priced at cost)		46,082	4
5	Short-Term Investments			5
6	Prepaid Insurance		140,324	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Taxes Receivable		238,488	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$ 4,603,226	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		2,281,557	12
13	Land		141,355	13
14	Buildings, at Historical Cost		13,540,264	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		5,791,579	16
17	Accumulated Depreciation (book methods)		(9,814,959)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		17,795	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 11,957,591	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$ 16,560,817	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 534,670	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		461,919	29
30	Accrued Salaries Payable		881,369	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Affiliates		435,841	36
37	Due to Third Parties		745,999	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$ 3,059,798	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		2,273,798	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Self Insurance Liability		595,222	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 2,869,020	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$ 5,928,818	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 10,631,999	$ 10,631,999	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 10,631,999	$ 16,560,817	48

***(See instructions.)**

Print Preview

Facility Name & ID Number Fayette County Hospital # 8000846 Report Period Beginning: 7/1/99 Ending: 6/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 10,526,687	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 10,526,687	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	110,916	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **FCH District Income**	101,382	15
16	Other (describe) **Reverse PY Audit Adjustments**	(106,986)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 105,312	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 10,631,999	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number Fayette County Hospital # 8000846 Report Period Beginning: 7/1/99 Ending: 6/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 26,357,296	1
2	Discounts and Allowances for all Levels	(11,492,192)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 14,865,104	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	470,026	10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	42,222	14
15	Telephone, Television and Radio	268	15
16	Rental of Facility Space	52,612	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	245,775	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 810,903	23
	D. Non-Operating Revenue		
24	Contributions	1,340	24
25	Interest and Other Investment Income***	43,724	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 45,064	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,721,071	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 716,795	31
32	Health Care	1,641,258	32
33	General Administration	2,898,042	33
	B. Capital Expense		
34	Ownership	0	34
	C. Ancillary Expense		
35	Special Cost Centers	199,699	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	OH Allocation from home office	65,000	37
38	Hospital & Overhead Expenses	10,089,361	38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,610,155	40
41	**Income before Income Taxes (line 30 minus line 40)****	110,916	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 110,916	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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Facility Name & ID Number Fayette County Hospital # 8000846 Report Period Beginning: 7/1/99 Ending: 6/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	26,222	26,510	442,470	16.69	3
4	Licensed Practical Nurses	17,542	17,612	206,222	11.71	4
5	Nurse Aides & Orderlies	77,540	78,094	568,562	7.28	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,480	2,549	20,924	8.21	9
10	Activity Assistants	3,488	3,496	27,134	7.76	10
11	Social Service Workers	518	525	3,715	7.08	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	4	4	51	12.75	14
15	Cook Helpers/Assistants	12,887	12,887	97,111	7.54	15
16	Dishwashers					16
17	Maintenance Workers	3,689	3,691	44,492	12.05	17
18	Housekeepers	9,335	9,316	61,021	6.55	18
19	Laundry	8,583	8,583	56,731	6.61	19
20	Administrator					20
21	Assistant Administrator	2,001	2,001	29,620	14.80	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,532	7,532	64,456	8.56	24
25	Vocational Instruction	5,716	5,741	104,465	18.20	25
26	Academic Instruction					26
27	Medical Director	453	453	9,529	21.04	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	177,990	178,994	$ 1,736,503 *	$ 9.70	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Fayette County Hospital # 8000846 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$

* Attach copy of IMRF notifications

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

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Facility Name & ID Number Fayette County Hospital # 8000846 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4		Not Applicable											
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Print Preview

Facility Name & ID Number Fayette County Hospital # 8000846 Report Period Beginning: 7/1/99 Ending: 6/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-10 years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ N/A Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease. No

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 56,268
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? Yes Indicate the amount. $ 29,187

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: Ernst & Young The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not received

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

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